FIS 0018 (4/03) Office of Financial & Insurance Services

Health Care-Request for External Review

You are eligible to request an External Review if you have received notice of an Adverse Determination or a Final Adverse Determination AND:

The patient has exhausted the health carrier's internal grievance process, UNLESS this requirement is waived because the health carrier did not complete their review within the required period of time.

This request is submitted within 60 days after receiving the Final Adverse Determination.

The patient was covered by the health benefit plan when the health care service was requested or provided.

The health care service appears to be covered under terms of the patient's health benefit plan.

An External Review is the process for resolving grievances when a health carrier issues a Final Adverse Determination (a notice of denial, reduction or termination) regarding a health care service.

Most health benefit policies from Health Insurers, Health Maintenance Organizations (HMOs), Alternative Finance and Delivery Systems (AFDS) and Blue Cross/Blue Shield of Michigan (BCBSM) are eligible for review under Michigan law.

These types of policies are NOT eligible for review: Medicare supplement, disability income, hospital indemnity, specified accident, credit, long term care and self funded plans.

PATIENT's Name | Name of INSURED person

Name of Health Carrier that this request for review is about — *Name of HMO, health insurer or Blue Cross/ Blue Shield of MI*

The Health Carrier is this type of company *(choose one if known)*

☐ a Health Insurer ☐ an HMO or Alternative Finance and Delivery System (AFDS) ☐ Blue Cross/Blue Shield of Michigan

Policy number | Claim number *(if applicable)* | Group number *(if applicable)*

Date service was received or requested — *If service was received, enter date received. If not, enter date service was requested.*

Summary of my Request for External Review Provide description of procedure, name of physician, clinic or facility if relevant to your request. Additional supporting documents helps us understand requests for review. Supporting documents could include statements from physicians, medical records, and research materials that support your position. If possible, use letter size (8.5 x 11") paper for all attachments.

ALWAYS SEND COPIES. NEVER SEND ORIGINAL DOCUMENTS.

Attach a copy of the Final Adverse Determination (not applicable if requesting an Expedited External Review)

Name of person filing this request

Address

City | State | Zip

Daytime phone number ( ) | Evening phone number ( )

Relationship to patient *(check each box that applies)*

☐ *I am the Patient*
☐ *I am the Insured Person*
☐ *Parent or Legal Guardian*
☐ *Spouse*
☐ *Primary caretaker*
☐ *Doctor or other health care provider*
☐ *Legal Representative*
☐ *Other: (describe below)*

Requesting an EXPEDITED External Review

Optional in certain cases, read below:

A covered person (or their representative) may request an EXPEDITED EXTERNAL Review within 10 days of receipt of an adverse determination, **ONLY IF BOTH OF THESE CONDITIONS ARE MET**: *(1) They have already requested an Expedited INTERNAL Review. (2) The adverse determination involves a medical condition for which the timeframe for an expedited Internal review would seriously jeopardize the life or health of the covered person, or would jeopardize their ability to regain maximum function.* ***This MUST be substantiated by a physician.***

My request meets these requirements. By completing items (1) and (2) below, I am requesting an Expedited External Review.

(1) Date you requested the Expedited ***Internal*** Review

(2) Name and phone number w/area code of substantiating Physician
Attach copy of Physician's statement of medical condition

Authorization—Release of Medical Records

I authorize the release of any health or medical information and medical records regarding this request to the Office of Financial and Insurance Services, the Independent Review Organization, the health carrier involved, and any other health care providers needed for the purpose of conducting this external review.

Signature of Patient or Authorized Representative | Date signed

Please send your Request for External Review with a copy of the Final Adverse Determination to:

Appeals Section
Office of Financial and Insurance Services
P.O. Box 30220
Lansing MI 48909-7720

Fax: 1-517-241-4168 *(for external reviews only)*

P.A. 251 of 2000 as amended, authorizes the Commissioner to review requests for external review. Submission of this form is required to request an external review by the Commissioner of the Office of Financial & Insurance Services.